Glossary of Terms

1. **Accrediting Body** means an entity that evaluates and recognizes facilities, agencies, institutions, and/or health care organizations as meeting certain predetermined standards. Accreditation is a voluntary and self-regulatory process for health care institutions including hospitals and managed care plans.

2. **Addendum** means an addition or change made to the Request for Proposal (RFP) before the Contract is signed into effect. The Contract will include addenda added to the RFP.

3. **Administrative Bulletin** means bulletins released to all potential proposers who have submitted a Letter of Interest, or entities that have requested to be placed on the RFP mailing list, that may include addenda or additional information and data.

4. **Aggregate Report** means a comprehensive report that provides results of the External Accountability Set Compliance Audit rates, Consumer Assessment of Health Plans Survey results, or other quality improvement studies or projects. The Aggregate Report must include, at a minimum, study methodology, limitations and caveats, plan-to-plan comparison, comparisons by plan model type, trending of individual plan performance, conclusions as to the quality of care provided by the health plans, a detailed assessment of the health plans' strengths and weaknesses, and recommendations for further improvement by the health plans.

5. **Attachments** means exhibits and special or unique materials relating to proposal and/or contract requirements attached to the RFP or contract and/or incorporated by reference.

6. **Benchmark** means the industry measure of the best performance for a particular indicator or performance goal. Benchmarking is the process of using industry leaders and the best demonstrated levels of excellence as the unit of comparison for one's own organization, with an ongoing effort to achieve and surpass that performance.

7. **Beneficiary** means a person who has been determined to be eligible for the Medi-Cal program.

8. **Bidder's Conference** means a planned, formally conducted meeting held after the release of the RFP document. The purpose is to clarify either or both the Technical Proposal and Cost Proposal documents and to respond to any questions from bidders.

9. **Center for Medicare and Medicaid Services (CMS)** means the federal agency responsible for administration of the Medicare and Medicaid programs. This agency was formerly known as the Health Care Financing Administration (HCFA).

10. **Change Order** means the document and/or the process used by the Department of Health Services for contract changes resulting in changes to the Contractor's responsibilities and, possibly, an adjustment to the Contractor's payment. A Change Order is distinguished from a contract amendment in that it is within the scope of the contract, is not a fundamental change to the nature of the contract, and does not require Contractor approval to implement.

11. **Commercial Plan (CP)** means a non-governmental health care plan administered by a private sector Health Maintenance Organization (HMO) to provide health care services to Medi-Cal beneficiaries under DHS's Two-Plan Model.

12. **Competitive Bidding** means a formal process used to obtain sealed Cost Proposals for the performance of a project or service. This process is conducted in a manner that does not limit competition to any one firm/individual and all competitors are bidding on exactly the same requirements.

13. **Confidential Information** means specific facts or documents identified as "Confidential" by law, regulation or contractual language.

14. **Consumer Assessment of Health Plan Survey (CAHPS®)** means a NCQA-developed assessment tool used to measure consumer satisfaction with the services provided by managed care plans. The survey allows for comparisons between competing plans at a local, regional and national level.

15. **Consultant** means an individual or organization that demonstrates specific expertise in a recognized area of medical or scientific research from whom the State seeks professional or technical advice or opinion.

16. **Contract** means the written agreement between the DHS and the Contractor.

17. **Contractor** means the individual, company, public entity or organization that has been awarded a contract; specifically, the organization that has been awarded the External Quality Review Organization contract (EQRO).

18. **Contract Effective Date** means the date upon which the terms of the Contract go into force. The date is specified in the contract on the standard contract form.

19. **Contract Manager** means the DHS official responsible for managing the Contract.

20. **Contract Number** means the seven-digit number assigned to the RFP and contract for tracking purposes. The Contract Number must be affixed to the proposal submissions and accompany all communications with DHS regarding the proposal or contract.

21. **Contracting Officer** means the responsible party within DHS who has the authority to enter into the Contract with the selected EQRO Contractor.

22. **Contractor's Representative** means the Contractor's official responsible for managing the Contractor's operation in performing the Contractor's obligations under this contract.

23. **Contract Requirement/Deliverable** means any service, deliverable or other duty that the Contractor is required to provide or perform under the terms of the Contract.

24. **Core Deliverables** means the minimum set of deliverables selected by the Department for performance of the EQRO contract. All Proposers must provide a bid for each core deliverable.

25. **Corrective Actions** means specific identifiable activities undertaken to address deficiencies or problems identified by formal audits, monitoring activities, or performance evaluations.

26. **Cost Proposal** means a sealed, written, dollar amount or price offered in response to a formal or informal request for bid.

27. **County Organized Health Systems (COHS)** means a local agency, with representation from providers, beneficiaries, local government, and other interested parties, created by a County Board of Supervisors to contract with the Medi-Cal Program for provision of health care services to all Medicaid beneficiaries who are residents of said county.

28. **Dedicated Staff** means staff that is solely assigned to perform work under a specified provision of this contract. Dedicated staff shall be strictly maintained at a level no less than that required in the RFP or proposed in the Technical Proposal, whichever is greater, and shall be guaranteed at that level for the life of the contract. Dedicated staff and any changes thereto, shall be identified by name, in writing, and may not be committed by the Contractor to work activities outside the areas of the contract section designating them as dedicated staff without prior written approval of the Contracting Officer. The functions of these dedicated staff shall be adjusted based upon the work requirements of the State.

29. **Department of Health Services (DHS)** means the State of California Department of Health Services, single State agency responsible for administration of Medi-Cal, Medi-Cal Managed Care, Maternal Child Health (MCH), Office of Clinical Preventative Medicine (OCPM), Children's Medical Services (CMS), California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health Disability and Prevent Program (CHDP), and other health related programs.

30. **Director** means the Director of the State of California Department of Health Services.

31. **DVBE** means Disabled Veterans Business Enterprise.

32. **Enhanced Deliverables** means those deliverables described within the Request for Proposal (RFP) which may or may not be required to be performed under the EQRO contract, but must be bid by each Proposer in response to the RFP. Enhanced deliverables will be selected for inclusion in the EQRO contract at the sole discretion of the Department.

33. **Exhibits** means terms and conditions which are grouped together by subject and incorporated into the RFP or contract by reference or attachment. Incorporated exhibits are legally binding and considered a part of the RFP or contract.

34. **External Accountability Set Compliance Audit** means the evaluation performed by the Contractor to assess the validity of the plans' reporting methodologies, medical record abstraction tools and processes, and calculation of rates for designated performance measures.

35. **EQRO Quality Review Program** means all activities and studies performed by the Contractor on behalf of the Department during the term of the EQRO contract.

36. **External Accountability Set** means a set of HEDIS® and Department-developed performance measures selected by the Department for evaluation of health plan performance.

37. **External Quality Review Organization (EQRO)** means a Peer Review Organization (PRO), PRO-like entity, or accrediting body that is an expert in the scientific review of the quality of health care provided to Medicaid beneficiaries in a state's Medicaid managed care plans.

38. **Federal Financial Participation (FFP)** means federal funds provided to match State and local expenditures made under approved state Medicaid programs.

39. **Fee-for-Service (FFS)** means a method of charging based upon billing for a specific number of units of services rendered to an eligible beneficiary. FFS is the traditional method of reimbursement used by physicians and other providers. Payments are made retrospectively (i.e., after the service has been rendered).

40. **Fully Executed Contract** means a contract that has received all necessary signatures and approvals.

41. **Geographic Managed Care (GMC)** means the GMC Program authorized by Section 14089 et. seq., of the W&I Code.

42. **Health Plan Employer Data and Information Set (HEDIS®)** means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

43. **HEDIS Compliance Audit** means an audit process that uses specific standards and guidelines for assessing the collecting, storing, analyzing and reporting of HEDIS measures. This audit process is designed to ensure accurate HEDIS reporting.

44. **Health and Safety Code** means the California State law relating to the preservation of the public health and safety including the health and safety of persons, custody of dead bodies, the safety and protection of property, and matters incidental thereto.

45. **Health Maintenance Organization** means a legal entity or organization that, through a coordinated system of health care, provides or assures the delivery of an agreed upon set of comprehensive health maintenance and treatment services for an enrolled group of persons through a predetermined periodic fixed prepayment. The term is defined in the Health Maintenance Act of 1973 (Public Law 93-222).

46. **Health Insurance Portability and Accountability Act (HIPAA)** means the HIPAA Act of 1996, Pub. L. 104-191, enacted on August 21, 1996. HIPAA amended the Public Health Service Act, the Employee Retirement Income Security Act of 1974 (ERISA), and the Internal Revenue Code of 1986 to provide for, among other things, improved continuity (also called "portability") and availability with respect to group health plan coverage and group health insurance provided in connection with employment, and insurance coverage in the individual insurance market.

47. **Local Initiative (LI)** means a locally developed Managed Care Plan created by a County to provide health care services to Medi-Cal beneficiaries under DHS's Two-Plan Model.

48. **Key Personnel** means those individuals employed by, or under subcontract to the Contractor, who assume primary responsibility for the activities identified in the scope of work, including administration and management of the EQRO contract. Key Personnel include, but are not limited to, physician consultants, nurse consultants, epidemiologists, biostatisticians, HEDIS auditors, project coordinators, the EQRO Program Manager, and the EQRO Contract Manager.

49. **Knox-Keene Health Care Service Plan Act of 1975** means the law that regulates HMOs and is administered by the Department of Managed Health Care (DMHC), commencing with Section 1340, Health and Safety Code.

50. **Letter of Interest** means a letter sent to the DHS by a potential Proposer expressing interest in submitting a Proposal in response to this RFP and

identifying the prime Contractor, address, liaison person(s) and any proposed subcontractor.

51. **Managed Care** means a planned, comprehensive approach to health care that combines clinical services and administrative procedures within a coordinated system constructed to provide cost-effective and timely access to primary health care.

52. **Medicaid** means the federal medical assistance program enacted by the 1965 Title XIX amendments to the Social Security Act.

53. **Medicaid HEDIS** means the adoption of the National Committee for Quality Assurance (NCQA) Health Plan Employer Data and Information Set (HEDIS) for use with Medicaid Managed Care programs. Medicaid HEDIS provides a standardized set of performance measures targeted to the needs of Medicaid beneficiaries enrolled in managed care plans.

54. **Medi-Cal** means the Title XIX Federal Medical Assistance Program (Medicaid) to provide Federal and State financial assistance for health and medical care of needy persons meeting program eligibility standards in California.

55. **Medical Records** means written documentary evidence of treatments rendered to a health plan member.

56. **Medical Review Criteria** means systematically developed statements that can be used to assess specific health care decisions, services, and outcomes.

57. **Member** means any eligible beneficiary who has enrolled in a contracted health plan.

58. **Minimum Performance Level** means a minimum requirement of performance of the Contractor on each of the performance measures selected by DHS.

59. **National Committee for Quality Assurance (NCQA)** means a not-for-profit organization committed to assessing, reporting and improving the quality of care provided by organized health care delivery systems.

60. **Non-clinical QIP** means a quality improvement project undertaken by a health plan, or group of plans, for the purpose of improving the quality of the health plans' services, systems, and/or administrative processes.

61. **Performance Measures** means the methods or instruments utilized to estimate or monitor the extent to which the actions of a health care practitioner conform to the standard clinical practice standards/guidelines.

62. **Plan-Specific Report** means a comprehensive report that provides results of the External Accountability Set Compliance Audit, Consumer Assessment of Health

Plan Survey, or other quality improvement studies or projects. The Plan-Specific Report must include, at a minimum, study methodology, limitations and caveats, trending individual plan performance, a detailed assessment of a health plan's strengths and weaknesses, conclusions as to the quality of care provided by the health plan, and recommendations for further improvement by the plan.

63. **Practice Standards/Guidelines** means systematically developed statements to assist practitioners and patients in decision-making concerning the appropriate medical care for specific clinical conditions. Practice standards/guidelines are developed by multidisciplinary panels of clinicians and other experts who employ scientific based evidence and expert clinical opinions to develop specific statements on patient assessment and management for specified clinical conditions. They reflect the current state of knowledge and publication on effective and appropriate medical care for the selected condition and must be updated and revised as indicated.

64. **Program** means any group of offices within DHS that fall organizationally under the direction of a Deputy Director whose primary purpose is to carry out a line function in support of the DHS mission.

65. **Proprietary** means ownership such as held under patent, trademark, or copyright. The term can include information, contract data which is unique to a company and which, in the hands of a competitor, would be detrimental to the company.

66. **Proposal** means a potential Contractor's sealed written proposal of costs, approaches and methods to be used in the performance of a particular service. Specifically, in this document, the Proposal is the written response to the RFP.

67. **Proposer** means a firm that submits a Proposal in response to the RFP.

68. **Provider** means any individual, partnership, clinic, group, association, corporation, institution, or public agency providing health care services according to applicable standards under a Medi-Cal managed care contract to provide health care services to Medi-Cal beneficiaries.

69. **Quality Assurance** means a formal set of activities to assure the quality of clinical and non-clinical services provided. Quality Assurance includes quality assessment and Corrective Actions taken to remedy any deficiencies identified through the Contractor's assessment process. Comprehensive Quality Assurance includes mechanisms to assess and assure the quality of both health services and administrative and support services.

70. **Quality Improvement (QI)** means the results of an effective quality assurance program that objectively and systematically monitors and evaluates the quality and appropriateness of care and services to members through Quality of Care studies and other health related activities.

71. **Quality Improvement Projects (QIPs)** means studies selected by Medi-Cal Managed Care Plans, either independently or in collaboration with the Department and other participating health plans, to be used for quality improvement purposes. The studies include four phases and may occur within a twenty-four (24) month timeframe.

72. **Quality Indicators** means measurable variables relating to a specific clinical area or health services delivery area which are reviewed over a period of time to screen delivered health care and to monitor the process or outcome of care delivered in that clinical area.

73. **Quality of Care** means the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with the current professional knowledge.

74. **Request for Proposal (RFP)** means the document that describes to prospective proposers the requirements of the EQRO program and the terms and conditions of the contract.

75. **Sample** means a subset of the population being studied.

76. **Scope of Work (SOW)** means work activities, actions to be performed, deliverables to be supplied, methods and approaches to be used and expected objectives and outcomes to be achieved under this contract.

77. **Standards of Quality** means authoritative statements of (1) minimum levels of acceptable performance or results; (2) excellent levels of performance or results; or (3) the range of acceptable performance or results.

78. **State** means the State of California.

79. **Subcontract** means a written agreement, including any amendments, entered into by the Contractor with any other organization or person[s], who became the subcontractor[s] and who agree[s] to perform any administrative or service function for the Contractor specifically related to fulfilling the Contractor's obligations to the DHS under the terms of this Contract.

80. **Technical Proposal** means the RFP response presented by a potential Contractor. that includes presentation of proposed activities and/or actions, including recommended approaches or methods to solve or meet a service need. The technical proposal does not include the amounts bid by the Proposer to perform the work required by the RFP.

81. **Term** means the starting and ending date of the Contract and/or the time allowed for the performance and completion of the Contract.

82. **Trend** means a pattern or apparent direction in outcomes of statistical significance.

83. **Turnover and Phaseout Period** means the three [3] month time period commencing the first day following completion of the operations period of the contract and ending on the date of contract termination.

84. **Validation** means a procedure that provides, by reference to independent sources, evidence that an inquiry (study), is free from bias and conforms to its declared purpose. In statistics, validation refers to a demonstration that the study sample is reasonably representative of the population under review and that the information collected is accurate.

85. **Welfare and Institutions Code (W&I)** means the California code of law which contains the Medi-Cal Act.

86. **Work Plan** means a plan used to specify the activities, deliverables, staff responsibilities, and their respective timelines for a specific contract period.